Medical Information Bureau: What it is and what it isn't

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In recent years there has been a growing interest in medical data files, especially those that are computer-based. Today concern is being expressed about the use and potential abuse of such computer banks, especially as they relate to privacy and confidentiality. Each of us needs to know what a particular file contains, what is its purpose, how confidentiality is maintained and how the individual can determine the contents of his own personal file with a view to assessing accuracy and correcting errors. Physicians have a responsibility to be informed on medical data banks and to advise their patients so that privacy and confidentiality can be protected. The purpose of this article is to provide Canadian physicians with information on a specialized computer-based medical file, the Medical Information Bureau (MIB).

What is MIB?

MIB is a non-profit, unincorporated trade association. It exchanges medical and certain nonmedical underwriting information between its member companies. More than 700 life insurance companies in Canada and the United States are members. One hundred and sixty-six companies are licensed to do life insurance business in Canada; of these 84 are Canadian companies. MIB membership is maintained by 66 of the Canadian companies and by 74 of the US and other foreign companies that do business in Canada.

The bureau operates under a constitution and extensive rules designed to protect the confidentiality of stored information on those who apply for insurance and to promote efficient operation. Eligible for membership is any licensed insurer in the US and Canada who offers life insurance on the level premium legal reserve plan. Each company, to qualify for membership, must have its medical affairs administered by a medical director who is a qualified physician and surgeon in good standing. The medical director is accountable for seeing that the rules are followed in his company.

One of the rules of membership is completion of a pledge to observe the MIB constitution and rules. The pledge is executed by the member's chief executive officer, medical director and chief underwriter.

Activities of the bureau are supervised by an executive committee of nine members elected by the entire membership. Four must be medical directors; the others are senior lay insurance company officers.

In 1890 a rejection exchange was founded by a group of life insurance medical directors to exchange information on the health of life insurance applicants. Its purpose was to protect against abuse that threatened to increase the cost of life insurance to policyholders by reason of "antiselection". This exchange was superseded in 1902 by a new exchange operated by the Association of Life Insurance Medical Directors of America (ALIMDA). A major reorganization in 1947 established the MIB as a separate institution with medical directors continuing to play a key supervisory and advisory role. The bureau has since grown and evolved, the major change in the past decade being automation.

Purposes, value

The constitution of the MIB states the purposes of the bureau:

a) to effectuate the free exchange among its members of underwriting and claims information with respect to applicants for insurance, insureds, and insurance claimants. The exchange of such information shall be effectuated in such a manner as may be deemed best to protect the confidential nature of the information exchanged and the interest with respect thereto of the applicants, insureds, and claimants as well as the insurers concerned.

b) to aid the members in their consideration of respective insurance risks by making available information which is relevant and necessary to careful underwriting procedures. This information shall not be considered a substitute for normal medical and inspection activities on the part of the member companies.

c) to help prevent the perpetration of fraud upon the members by applicants for insurance who conceal facts relevant to the determination of the insurance risk.

d) to act as a central bureau for medical-actuarial statistics and to assist in mortality, morbidity and related studies.

Bureau's main purpose

Briefly, the main purpose of the bureau is to alert members to information essential in evaluating risks for life insurance. Risk is thus assessed equitably at a reasonable underwriting cost, resulting in lower premiums for insurance consumers. Reports presented at the 1975 meeting of the Home Office Life Underwriters Association supported again the cost-effective value of the bureau.[1]

The conclusion of a non-industry observer adds support to these findings.

> The MIB serves an invaluable function in the life insurance industry by meeting underwriters' informational needs. The proved ability to set premiums which result from the use of the MIB benefits the policyholders. It is they who bear the burden of increased costs if an applicant is assessed for premiums inadequate to cover the risk of loss he represents.[2]

As stated in the opening paragraph it is essential for individuals to know what files about them may contain. The bureau does not store an individual's complete medical record, nor

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does it store the insurance company's file on the client. Only the highlights of a medical record are recorded in a brief three-digit code form. These are maintained on file for 7 years, after which they are automatically eliminated.

A report consists of an applicant's name, date and place of birth, area of residence and occupation (MIB's identifiers for file purposes) followed by one or more three-digit codes and letter suffixes. These indicate any reportable conditions and times of occurrence (see Table I). An average report contains only two or three coded entries.

The coding system used is purposely kept insufficient so that detailed or complete medical histories cannot be reported. Many of the code definitions are of a general nature — for example, gout, multiple sclerosis, coronary artery disease, retinal hemorrhage or detachment and diabetes mellitus. Only authorized underwriting and claims personnel have access to the code; the information is not available to sales personnel.

Each member company must report significant underwriting information received with preliminary or completed formal applications for personal insurance. The reports are compiled from MIB's official code list of impairments. Of the information maintained by MIB, 90% is medical underwriting information, but there are a few nonhealth factors (such as aviation or participation in hazardous sports) of significant interest to underwriters. Favourable information is reported as well as unfavourable.

No report may be made of the amounts of insurance issued or not issued, nor of underwriting or claims decisions.

Information is submitted by member companies only, and then only on about 12% of applicants. The sources of the company's information include hospitals, attending physicians, insurance examinations and the applicant himself. The bureau does not employ investigators, examine applicants or use any consumer reporting agencies.

Table I—Example of MIB report

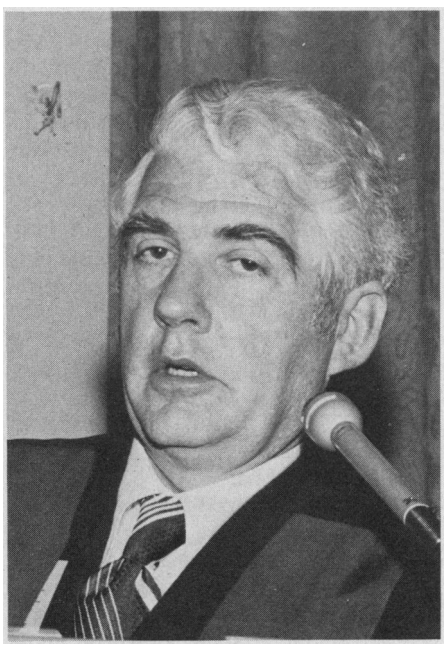
Coded Report*	Interpretation
CANUCK, John A.	Name
16FB20 ONT	Birthdate and Place
PHYS	Occupation
CANADA (shown as a letter)	Area of Residence
13MY77	Date of Report
123AB-345CD-789EFG	— ECG, two or more, last within 1 year, normal
	— Gall bladder disorder. Treated by surgical operation within 2nd year.
	— Duodenal ulcer, two or more attacks, most recent attack within 3-4-5 years, under treatment not surgical.

*Codings shown for medical conditions are hypothetical examples and not those in actual use

Strict security

The information is stored in a computer data file. The bureau retains a servicing agent, the recording and statistical division of Sperry Rand Corporation (R&S), to administer MIB records and correlate all information received from the members. There is strict security at the computer site; R&S personnel cannot decipher reported codes because they do not have access to any code books.

MIB information is released only upon an applicant's consent and only when a member company has a bona fide application for insurance. If there is information on file, it is received in code form. The report does not contain the action taken by the original, reporting company, that is, whether the application was rated, declined or restricted. The second company may be alerted by information contained in the report, but under the rules it may not base its own decision on the MIB codes — in fact, there simply isn't enough information in an MIB report for an insurer to do so. The second company must conduct its own independent underwriting investigation and arrive at its own decision, which may be quite different from that of the original reporting company. The second company must report its own findings. Information on bureau files is not available to credit bureaus, consumer reporting agencies, government agencies or nonmember companies.



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A member must correct or eliminate reports it has made that are subsequently found to be based on inaccurate data. Members must also notify MIB when they believe another member's report may not be correct. After receiving an MIB report and also having either obtained a statement from a medical source or completed a medical examination, the member company may request, through the servicing agency, details of coded reports from the original reporting member. The response to such a request is entirely at the discretion of the medical director of the original reporting company. He may decline to furnish details or to disclose his company's identity, he may decide to supply only the name and address of the information source or he may furnish detailed information.

During the 2 years following an initial inquiry on any issued policy, a member, as a subscriber to the MIB follow-up plan, may be alerted to additional later reports made to the bureau during this "contestable" period. This is further protection against misrepresentation in the original application.

Consumer protection

The general rules of the MIB require that the member company advise each applicant for insurance about MIB. This is done by a written prenotice, as prescribed by the executive committee. This document is furnished to the applicant before he completes the application. It informs the applicant of MIB's existence and operations, the possibility that a report may be made to the MIB and the availability of procedures for disclosure and challenging accuracy. A member cannot report to or receive information from MIB unless prenotice has been given. Further, no member shall request MIB record information pertaining to an individual without having first obtained that individual's written consent on a form expressly naming MIB as an authorized source. The prenotice and authorization wordings are shown in Fig. 1.

The prenotice contains the telephone number and address of the MIB information office (330 University Ave., Ste 403, Toronto M5G 1R7; 416-597-0590). Upon request and proper identification MIB will clearly and accurately disclose to the applicant the nature, substance and source (that is the name of the reporting member company) of all nonmedical information on the applicant that it has in its files. Alternatively it will disclose the source of

Pre-Notice Form Canada

Information regarding your insurability will be treated as confidential. XYZ Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of Life Insurance Companies, which operates an information exchange on behalf of its members. If you apply to another bureau member company for Life or Health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such a company with the information in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to the attending physician). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. The address of the Bureau's Information Office is:

Medical Information Bureau
330 University Avenue — Suite 403
Toronto, Ontario, Canada
M5G 1R7
Telephone No. 416-863-0518

XYZ Company may also release information in its file to other Life Insurance Companies to whom you may apply for Life or Health Insurance, or to whom a claim for benefits may be submitted.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the XYZ Life Insurance Company any such information.

A photographic copy of this authorization shall be as valid as the original.

FIG. 1—Prenotice form as prescribed by MIB executive committee. MIB rules require that the authorization should contain substantially the language above.

all medical information in its files on the applicant. On additional request, the bureau will advise an applicant of the recipients of any MIB report on him that it has furnished within the preceding 6 months.

Upon receipt of the applicant's written request, the bureau will request the reporting company to disclose to the applicant's designated physician at least the meanings of the codes reported to MIB and the results of its medical examinations.

Where the member company's medical report has been based on statements of an attending physician, hospital, clinic or other medical or medically related facility, the medical director of the reporting company will take reasonable action to see that the applicant's current attending physician is advised of the meanings of the codes, of the source of the information and, if ethical, the content of the statements. In other words, all medical information is released through the applicant's own physician and the company has an opportunity to amplify the basic disclosure with the documentation in its underwriting file when it feels it is helpful or advisable to do so.

Inaccurate records can be corrected. During the underwriting process a member company is required to correct any error it discovers. The applicant can have errors corrected on disclosure of file information.

Other procedures protect the privacy and confidentiality of the consumer's records. The member company is required to conduct a self audit, reviewable by MIB staff, to determine whether it has complied with MIB's constitution and rules and whether its internal procedures have protected the privacy of individuals and the confidentiality of MIB record information and code books. In addition, MIB has field auditors who visit each member company every 2 years. Unsatisfactory performance and noncompliance with MIB rules may be reported to the executive committee for appropriate disciplinary action.

In 1970 the liaison committee of ALIMDA and the Society of Actuaries recommended that "the MIB system might well be utilized for statistical information, not only of underwriting value to the life insurance industry, but also of substantial benefit to the medical profession, and thus to the general public". Such a centre could serve other purposes. Actuaries would find helpful a system of collecting and studying industry experience on the mortality associated with build, blood pressure and medical impairments. Current intercompany experience would provide a statistical base to review the fairness of today's underwriting practices. Studies are supervised by the liaison committee with day-to-day guidance provided by a committee-appointed actuary. In 1973 the first study was undertaken, a comprehensive investigation of the mortality of insured lives according to variation in body build, height, weight and blood pressure. This should be available in 1978, updating a similar study concluded in 1959. A second intercompany study on auricular fibrillation and mortality is now being conducted.

Summing up

Alan F. Westin, professor of public law and government, Columbia University, has stated:

> In order to delimit privacy, it seems to me, an organization must ask itself three questions:
> What kinds of information need to be collected — that is, what data are essential to the assigned function of the organization, and where can the boundary be drawn between what might be called "intrusive" data collection and a routine gathering of information that is socially and legally acceptable?
> Who has the right to use the information within the organization — and with whom, if anyone, should it be shared outside the organization?
> When do individuals get to know what is in their records, and when are they given procedures for contesting and correcting them?[3]

MIB by its rules and procedures on consumer protection, confidentiality, operations and administration has provided satisfactory answers to these questions. Further, it has dealt fully with the question of confidentiality by protecting its facilities against unauthorized access or disclosure. MIB continues to serve the public in helping to prevent antiselection, thus keeping costs of insurance as low as economics allow by reducing the need for extra mortality cost and more extensive and expensive underwriting procedures. Physicians continue to be involved in the management of the bureau, while the medical director of each company is accountable in the day-to-day operations.

References

1. *Proceedings, Home Office Life Underwriters Association annual meeting, 1975,* Kansas City, McWhirter, 1975
2. STERN LC: Medical Information Bureau: The Life Insurer's Databank. *Rutgers Journal of Computers and the Law* 4: 1, 1974
3. WESTIN AF: The Problem of Privacy and Security with Computerized Data Collection. *The Conference Board Record* March 1974